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103D CONGRESS
2D SESSION

H. R. 4769

To amend the Internal Revenue Code of 1986 to provide for the treatment of long-term care insurance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 14, 1994

Ms. SNOWE introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend the Internal Revenue Code of 1986 to provide for the treatment of long-term care insurance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—TAX TREATMENT OF LONG-TERM CARE INSURANCE

SEC. 101. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this title—

''(1) a long-term care insurance contract shall be treated as an accident or health insurance contract,

''(2) amounts received under such a contract with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

''(3) any plan of an employer providing qualified long-term care services shall be treated as an accident or health plan.

''(b) LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

''(B) the maximum benefit under the policy (or certificate for a group long-term care insurance policy) for expenses incurred for any day does not exceed $200.00,

''(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(D) such contract is guaranteed renewable,

''(E) such contract does not have any cash surrender value, and

''(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(2) SPECIAL RULES.—

''(A) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(B) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

''(C) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses

incurred or services rendered during the period to which the payments relate.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section:

''(1) IN GENERAL.—The term 'qualified long-term care services' means—

''(A) necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

''(i) are required by a chronically ill individual in a qualified facility, and

''(ii) are provided pursuant to a plan of care prescribed by a licensed health care practitioner; or

''(B) payments made on a per diem or other periodic basis without regard to the expenses incurred or services rendered during the period to which the payments relate and which are payable to a chronically ill individual in a qualified facility who is receiving treatment pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has

been certified by a licensed health care practitioner as—

''(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

''(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

''(i) which is licensed under State law, or

''(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

''(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

''(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

''(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy con-

tinuation coverage requirements of group health plans) applies.

''(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

''(1) IN GENERAL.—In the case of a calendar year after 1995, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year or 5 percent per year, whichever is greater. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1994.''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart E is amended by inserting after the item relating to section 818 the following new item:

''Sec. 818A. Treatment of long-term care insurance or plans.''

SEC. 102. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE; INCLUSION OF EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking ''and'' at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting '', and'', and by inserting after paragraph (4) the following new paragraph:

''(6) benefits under a long-term care insurance contract (as defined in section 818A(b)).''

(b) INCLUSION OF EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end thereof the following sentence: ''The preceding sentence shall not apply to any plan providing coverage for qualified long-term care services.''

SEC. 103. CREDIT FOR QUALIFIED LONG-TERM CARE PREMIUMS.

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. LONG-TERM CARE INSURANCE CREDIT.

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the eligible long-term care premiums paid during such taxable year for such individual or the spouse of such individual.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the term 'applicable percentage' means 31 percent reduced (but not below zero) by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the base amount.

''(2) BASE AMOUNT.—For purposes of paragraph (1), the term 'base amount' means—

''(A) except as otherwise provided in this paragraph, $25,000,

''(B) $40,000 in the case of joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year (within the meaning of section 7703) but does not file a joint return for such taxable year, and

''(ii) does not live apart from his or her spouse at all times during the taxable year.

''(c) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(1) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

''(2) INDEXING.—

''(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1995, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(B) MEDICAL CARE COST ADJUSTMENT.—For purposes of subparagraph (A), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(i) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(ii) such component for August of 1994.

''(d) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount allowed as a credit under this section shall not be taken into account under section 213.''

(b) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following:

''Sec. 35. Long-term care insurance credit.
''Sec. 36. Overpayments of tax.''

SEC. 104. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as

subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 818A(c)), or''

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

''In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term

care premiums (as defined in section 35(c)) shall be taken into account under subparagraph (D).''

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 105. TAX RESERVE TREATMENT OF LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Subparagraph (A) of section 807(d)(3) of the Internal Revenue Code of 1986 (relating to tax reserve method) is amended—

(1) by redesignating clause (iv) as clause (v),

(2) by striking ''or (iii)'' each place it appears in clause (v) (as so redesignated) and inserting ''(iii), or (iv), and

(3) by inserting after clause (iii) the following new clause:

''(iv) LONG-TERM CARE INSURANCE CONTRACTS.—In the case of any long-term care insurance contract, a one-year full preliminary term method.''

(b) TECHNICAL AMENDMENT.—Clause (iii) of section 807(d)(3)(A) of such Code is amended by inserting ''other than a long-term care insurance contract,'' after ''contract,''.

SEC. 106. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS OR 401(k) PLANS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS AND SECTION 401(k) PLANS FOR LONG-TERM CARE INSURANCE.

''(a) GENERAL RULE.—The amount includible in the gross income of an individual for the taxable year by reason of qualified distributions during such taxable year shall not exceed the excess of—

''(1) the amount which would (but for this section) be so includible by reason of such distributions, over

''(2) the aggregate premiums paid by such individual during such taxable year for any long-term care insurance contract (as defined in section 818A) for the benefit of such individual or the spouse of such individual.

''(b) QUALIFIED DISTRIBUTION.—For purposes of this section, the term 'qualified distribution' means any distribution to an individual from an individual retirement account or a section 401(k) plan if such individual has attained age 59½ on or before the date of the distribution (and, in the case of a distribution used to pay premiums for the benefit of the spouse of such individual, such spouse has attained age 59½ on or before the date of the distribution).

''(c) DEFINITIONS.—For purposes of this section:

''(1) INDIVIDUAL RETIREMENT ACCOUNT.—The term 'individual retirement account' has the meaning given such term by section 408(a).

''(2) SECTION 401(k) PLAN.—The term 'section 401(k) plan' means any employer plan which meets the requirements of section 401(a) and which in-

cludes a qualified cash or deferred arrangement (as defined in section 401(k)).

''(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

''(1) WITHDRAWALS CANNOT EXCEED ELECTIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR DEFERRED ARRANGEMENT.—This section shall not apply to any distribution from a section 401(k) plan to the extent the aggregate amount of such distributions for the use described in subsection (a) exceeds the aggregate employer contributions made pursuant to the employee's election under section 401(k)(2).

''(2) WITHDRAWALS NOT TO CAUSE DISQUALIFICATION.—A plan shall not be treated as failing to satisfy the requirements of section 401, and an arrangement shall not be treated as failing to be a qualified cash or deferred arrangement (as defined in section 401(k)(2)), merely because under the plan or arrangement distributions are permitted which are excludable from gross income by reason of this section.''

(b) CONFORMING AMENDMENTS.—

(1) Section 401(k) of such Code is amended by adding at the end the following new paragraph:

''(11) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals for payment of long-term care premiums, see section 137."

(2) Section 408(d) of such Code is amended by adding at the end the following new paragraph:

''(8) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals from individual retirement accounts for payment of long-term care premiums, see section 137."

(3) The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 137. Distributions from individual retirement accounts and section 401(k) plans for long-term care insurance.
''Sec. 138. Cross references to other Acts.''

SEC. 107. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

Section 101 of the Internal Revenue Code of 1986 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid or advanced to an individual under a life insurance contract on the life of an insured—

''(A) who is a terminally ill individual, or

''(B) who is a chronically ill individual (as defined in section 818A(c)(2)) who is confined to a qualified facility (as defined in section 818A(c)(3)(A)),

shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 12 months or fewer.

''(3) PHYSICIAN.—For purposes of this subsection, the term 'physician' has the meaning given to such term by section 213(d)(4).''

SEC. 108. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part:

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of a life insurance contract which provides for payments to an individual on the life of an insured upon such insured—

''(A) becoming a terminally ill individual (as defined in section 101(g)(2)), or

''(B) becoming a chronically ill individual (as defined in section 818A(c)(2)) who is confined to a qualified facility (as defined in section 818A(c)(3)(A)).''

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(1) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Paragraph (5)(A) of section 7702(f) of such Code is amended by striking ''or''

at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)(2)) or any long-term care insurance contract rider which reduces the death benefit, or''.

(2) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) or payments for qualified long-term care services (as defined in section 818A of such Code) shall not be treated as a modification or material change of such contract.

SEC. 109. QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS PERMITTED TO BE OFFERED IN CAFETERIA PLANS.

(a) IN GENERAL.—Paragraph (2) of section 125(d) of the Internal Revenue Code of 1986 (relating to exclu-

sion of deferred compensation) is amended by adding at the end thereof the following new subparagraph:

''(D) EXCEPTION FOR LONG-TERM CARE INSURANCE CONTRACTS.—For purposes of subparagraph (A), a plan shall not be treated as providing deferred compensation by reason of providing any long-term care insurance contract (as defined in section 818A(b)) if—

''(i) the employee may elect to continue the insurance upon cessation of participation in the plan, and

''(ii) the amount paid or incurred during any taxable year for such insurance does not exceed the premium which would have been payable for such year under a level premium structure.''

SEC. 110. EFFECTIVE DATE.

The amendments made by this title shall apply to taxable years beginning after December 31, 1994.

TITLE II—ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE

SEC. 201. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

''PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

"SEC. 2701. STANDARDS.

''(a) APPLICATION OF STANDARDS.—

''(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the 'NAIC')—

''(A) develop specific standards that incorporate the requirements of this title; and

''(B) report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

''(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

''(3) RELATION TO STATE LAW.—Nothing in this title shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this title, except that such State standards may not be inconsistent or in conflict with any of the requirements of this title.

''(b) DEADLINE FOR APPLICATION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

''(A) the date the State adopts the standards established under subsection (a)(1); or

''(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

''(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

''(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

''(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legis-

lature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

''(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

''(2) standards for the enhanced protection of consumers with long-term care insurance;

''(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

''(4) other activities determined appropriate by Congress.

''(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

''(1) three individuals who are representatives of carriers;

''(2) three individuals who are representatives of consumer groups;

''(3) three individuals who are representatives of providers of long-term care services;

''(4) three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and

''(5) the Secretary of Veterans Affairs.

''(e) DUTIES.—The advisory committee established under subsection (d) shall—

''(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

''(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

''(3) recommend appropriate standards for benefits under section 2715(c); and

''(4) perform such other activities as determined appropriate by the Secretary.

''(f) ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act

shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

''(1) Subparagraph (C) (relating to staffing and administration).

''(2) Subparagraph (D) (relating to compensation of members).

''(3) Subparagraph (F) (relating to access to information).

''(4) Subparagraph (G) (relating to use of funds).

''(5) Subparagraph (H) (relating to periodic GAO audits).

''(6) Subparagraph (J) (relating to requests for appropriations).

''PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

''(a) IN GENERAL.—

''(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

''(A) the Secretary determines that the State has established a regulatory program that—

''(i) provides for the application and enforcement of the standards established under section 2701(a); and

''(ii) complies with the requirements of subsection (b);

by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

''(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

''(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701 (a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

''(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

''(1) ENFORCEMENT.—The enforcement under the program—

''(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of non-compliance with such standards; and

''(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

''(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

''(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

''(B) responding on a timely basis to such complaints;

''(C) the investigation of—

''(i) those complaints which have a reasonable probability of validity, and

''(ii) such other alleged violations of the standards as the program finds appropriate; and

''(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

''(3) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

''(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

''(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

''(4) PROCESS FOR APPROVAL OF PREMIUMS.—

''(A) IN GENERAL.—Each State regulatory program shall—

''(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

''(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

''(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

''(i) includes a description of the assumptions that justify the increase;

''(ii) contains such information as may be required under the Standards; and

''(iii) is made available to the public.

''(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

''(D) EXCEPTION.—Subparagraph (C) shall not apply to—

''(i) group conversion policies;

''(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

''(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

''(5) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

''(6) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

''(7) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

''(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

''(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

''(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

''(B) for responding on a timely basis to such complaints; and

''(C) for the investigation of—

''(i) those complaints that have a reasonable probability of validity; and

''(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

''(3) HEARINGS.—

''(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

''(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's

imposition of the order shall constitute a final and unappealable order.

''(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

''(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

''(ii) administrative law judges may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

''(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing

under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

''(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

''(i) shall require the agent, association or its subsidiary, or a carrier—

''(I) to cease and desist from such violations; and

''(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

''(ii) may require the agent, association or its subsidiary, or a carrier to take

such other remedial action as is appropriate.

''(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

''(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

''(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

''(C) WAIVER BY SECRETARY.—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

''(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

''(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

''(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity

and appropriateness of the final order shall not be subject to review.

''(d) DEMONSTRATION GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary may award grants to States for the establishment of demonstration programs to improve the enforcement within such States of long-term care insurance standards applicable under this title.

''(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State intends to use the amounts provided under the grant.

''(3) MINIMUM AMOUNT OF GRANTS.—The amount of a grant awarded under this subsection shall not be less than $100,000.

''(4) EVALUATION.—A State that receives a grant under this subsection shall comply with such evaluation procedures as the Secretary shall by regulation establish. The Secretary shall utilize such evaluations to conduct an overall evaluation of the results of the demonstration programs established under this section.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $5,000,000 for each of the fiscal years 1993 through 1997.

"SEC. 2712. REGULATION OF SALES PRACTICES.

''(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

''(1) IN GENERAL.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

''(2) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

''(A) TWISTING.—

''(i) IN GENERAL.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

''(ii) POLICY REPLACEMENT FORM.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

''(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

''(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that con-

tact will be made by an insurance agent or insurance company.

''(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

''(b) FINANCIAL STANDARDS.—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

''(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

''(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

''(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

''(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

''(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

''(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

''(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

''(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) without providing to the purchaser or potential purchaser (or representative) an outline of coverage that com-

plies with the standards established under section 2701(a).

''(g) PENALTIES.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation.

''(h) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The NAIC shall establish requirements for long-term care insurance agent training and certification that—

''(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

''(2) specify procedures for certifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

''(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

''(b) MAILING OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written request by the policyholder or certificate holder (or representative)—

''(1) provide a written explanation of the reasons for the denial; and

''(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

''(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

''(1) the long-term care insurance policies of the carrier that are in force;

''(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

''(3) the lapse rate, replacement rate, and rescission rates by policy;

''(4) the names of that 10 percent of its agents that—

''(A) have the greatest lapse and replacement rate; and

''(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

''(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

"SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

''(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

''(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

''(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

''(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

''(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

''(A) whose coverage under the group policy would otherwise be terminated for any reason; and

''(B) who has been continuously insured under the policy (or group policy which was re-

placed) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

''(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

''(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

''(c) STANDARDS FOR ISSUANCE.—

''(1) IN GENERAL.—

''(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such poli-

cies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

''(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

''(2) UPGRADE FOR CURRENT POLICIES.—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

''(d) EFFECT OF INCAPACITATION.—

''(1) IN GENERAL.—

''(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

''(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

''(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

''(A) the period of such nonpayment is in excess of 30 days; and

''(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"SEC. 2715. BENEFIT STANDARDS.

''(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

''(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers;

''(2) use a uniform format for presenting the outline of coverage under such a policy; and

''(3) provide coverage for at least one standard benefits package (of those developed by the NAIC) that shall include the limitations on the amount of

payments per day and the lengths of covered stays for nursing facility and home health care services;

as prescribed under guidelines issued by the NAIC and periodically updated.

''(b) DISCLOSURE.—

''(1) OUTLINE OF COVERAGE.—

''(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

''(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

''(i) A description of the principal benefits and coverage under the policy.

''(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

''(iii) A statement of the terms under which the policy (or certificate) may be

continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

''(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

''(v) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

''(vi) Information on national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs, where available.

''(vii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

''(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

''(A) a description of the principal benefits and coverage provided in the policy;

''(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

''(C) a statement that the group master policy determines governing contractual provisions.

''(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

''(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

''(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

''(C) any exclusions, reductions, and limitations on benefits of long-term care.

''(4) ADDITIONAL INFORMATION.—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

''(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

''(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

''(A) for benefits for a type of services to the need for or receipt of any other services;

''(B) for any benefit on the medical necessity for such benefit;

''(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws

exists, in compliance with qualifications developed by the NAIC; or

''(D) for residential care (if covered under the policy) only—

''(i) to care provided in facilities which provide a higher level of care; or

''(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

''(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

''(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

''(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

''(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

''(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

''(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

''(4) PER DIEM POLICIES.—

''(A) DEFINITION.—For purposes of this title, the term 'per diem long-term care insurance policy' means a long-term care insurance

policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condition or otherwise exclude benefit payments based on the receipt of any type of nursing facility, home health care or community-based services.

''(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

''(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

''(1) INITIAL ISSUANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

''(B) 6-MONTH LIMIT.—

''(i) IN GENERAL.—No long-term care insurance policy or certificate issued under this title shall utilize a definition of 'preexisting condition' that is more restrictive than the following: The term 'preexisting condition' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

''(ii) PROHIBITION ON EXCLUSION OF COVERAGE.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months fol-

lowing the effective date of the coverage of the insured individual.

''(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

''(f) ELIGIBILITY FOR BENEFITS.—

''(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

''(A) describe the level of benefits available under the policy; and

''(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

''(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the

qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term 'control' means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

''(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

''(4) APPEALS PROCESS.—

''(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, con-

ducted under paragraph (3), of the claimant's functional assessment, conducted under paragraph (2).

''(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

''(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

''(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

''(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

''(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

''(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

''(g) INFLATION PROTECTION.—

''(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

''(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in bene-

fits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

''(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

''(i) the existing policy benefit; and

''(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

''(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

''(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

''(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this title:

''(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

''(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

''(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

''(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

''(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2716. NONFORFEITURE.

''(a) IN GENERAL.—Each long-term care insurance policy (or certificate) may provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

''(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

Such standards shall apply only to policies which provide nonforfeiture benefits.

"SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

''(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or material misrepresentation relating to the issuance of the policy unless notice of such fraud or material misrepresentation is provided within a time period to be determined by the NAIC.

''(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2718. CIVIL MONEY PENALTY.

''(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) provides a commission or compensation in violation of section 2713(e);

''(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

''(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

''PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

''(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

''(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

''(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(b) ISSUANCE.—Long-term care insurance policies may be issued by—

''(1) carriers;

''(2) fraternal benefit societies;

''(3) nonprofit health, hospital, and medical service corporations;

''(4) prepaid health plans;

''(5) health maintenance organizations; or

''(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

''(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in

which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(d) APPLICATIONS.—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

''Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

''(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

''(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

''(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

''(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or

association receives) from the endorsement or sale of the policy to its members.

''(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

''PART D—MISCELLANEOUS PROVISIONS

"SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE.

''(a) IN GENERAL.—The Secretary, acting through the Public Health Service, may award grants to States, and national organizations with demonstrated experience in long-term care insurance, for the establishment of programs to provide information, counseling, and assistance relating to the procurement of adequate and appropriate long-term care insurance.

''(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a State or national organization shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a descrip-

tion of the program for which the State or organization intends to use the amounts provided under the grant.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriate for grants to States under subsection (a), $10,000,000 for each of the fiscal years 1994 through 1996.

''(2) NATIONAL ORGANIZATIONS.—There are authorized to be appropriate for grants to national organizations under subsection (a), $1,000,000 for each of the fiscal years 1994 through 1996.

"SEC. 2732. DEFINITIONS.

''As used in this title:

''(1) AGENT.—The term 'agent' means—

''(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is licensed or required to be licensed under State law for such purpose; and

''(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2712(f).

''(2) ASSOCIATION.—The term 'association' includes the association and its subsidiaries.

''(3) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).''.

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking out ''2701'' each place that such appears and inserting in lieu thereof ''2801''.

TITLE III—DEDUCTION FOR CERTAIN EXPENSES FOR DEPENDENTS WITH ALZHEIMER'S DISEASE OR RELATED ORGANIC BRAIN DISORDERS

SEC. 301. DEDUCTION ALLOWANCE FOR HOME HEALTH CARE AND ADULT DAY AND RESPITE CARE EXPENSES OF INDIVIDUALS FOR DEPENDENTS WITH ALZHEIMER'S DISEASE OR RELATED ORGANIC BRAIN DISORDERS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. HOME HEALTH CARE AND ADULT DAY AND RESPITE CARE EXPENSES FOR DEPENDENTS WITH ALZHEIMER'S DISEASE OR RELATED ORGANIC BRAIN DISORDERS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who maintains a household which includes a qualified dependent of such individual, there shall be allowed as a deduction the qualified home health care and adult

day respite care expenses of such individual with respect to such dependent.

''(b) DEFINITIONS.—For purposes of this section:

''(1) QUALIFIED DEPENDENT.—The term 'qualified dependent' means any individual (including the spouse of the taxpayer but not including the taxpayer) who—

''(A) has as his principal place of abode the principal residence of the taxpayer, and is a member of the taxpayer's household, for more than 180 days of the calendar year during which the taxable year of the taxpayer begins,

''(B) is a dependent of the taxpayer (within the meaning given to such term by subsection (a) of section 152 other than paragraph (9) of such subsection) for such calendar year, and

''(C) at the close of such calendar year, suffers from Alzheimer's disease (or a related organic brain disorder) and is physically or mentally incapable of caring for himself, as determined by a physician.

''(2) QUALIFIED HOME HEALTH CARE AND ADULT DAY AND RESPITE CARE EXPENSES.—The

term 'qualified home health care and adult day and respite care expenses' means the excess of—

''(A) the reasonable and necessary expenses paid or incurred by the taxpayer for—

''(i) household services for a qualified dependent, and

''(ii) the care (including respite care) of such dependent in the home or in an adult day care center, over

''(B) the reasonable and necessary expenses such taxpayer would have paid or incurred for household services for, and the care of, such qualified dependent if such dependent had been capable of caring for himself.

''(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

''(c) SPECIAL RULES.—For purposes of this section:

''(1) MAINTAINING A HOUSEHOLD.—An individual shall be treated as maintaining a household for any period only if over half the cost of maintaining the household for such period is furnished by such individual (or, if the individual is married, by the individual and his spouse).

''(2) MARRIED COUPLE MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the deduction shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return under section 6013 for the taxable year.

''(d) CERTIFICATION OF DIAGNOSIS BY PHYSICIAN.—Any determination by a physician that—

''(1) an individual suffers from Alzheimer's disease or a related organic brain disorder, and

''(2) such individual is mentally or physically incapable of caring for himself,

shall be certified by the physician to the Secretary at such time and in such manner as the Secretary shall by regulation prescribe.

''(e) COORDINATION WITH SECTIONS 36 AND 213.—If any amount allowable as a deduction under this section would (but for this subsection) also be taken into account for purposes of determining the amount of any credit allowable under section 21 (relating to expenses for household and dependent care services necessary for gainful employment) or any deduction allowable under section 213 (relating to medical, dental, etc. expenses), this section shall apply only if the taxpayer elects its application. If this section is elected with respect to any amount, such

amount shall not be taken into account under section 36 or 213. Such election shall be made at such time and in such manner as the Secretary shall by regulation prescribe.''

(b) DEDUCTION ALLOWED IN ARRIVING AT ADJUSTED GROSS INCOME.—Section 62(a) of such Code (defining adjusted gross income) is amended by inserting after paragraph (13) the following new paragraph:

''(14) QUALIFIED HOME HEALTH CARE AND ADULT DAY AND RESPITE CARE EXPENSES.—The deduction allowed by section 220.''

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 220. Home health care and adult day and respite care expenses for dependents with Alzheimer's disease or related organic brain disorders.
''Sec. 221. Cross reference.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

TITLE IV—DEPENDENT CARE CREDIT EXPANDED AND MADE REFUNDABLE

SEC. 401. DEPENDENT CARE TAX CREDIT EXPANDED AND MADE REFUNDABLE.

(a) DEPENDENT CARE SERVICES.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. DEPENDENT CARE SERVICES.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an individual who maintains a household which includes as a member 1 or more qualifying individuals, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the sum of—

''(A) the employment-related expenses paid by such individual during the taxable year, plus

''(B) the respite care expenses paid by such individual during the taxable year.

''(2) APPLICABLE PERCENTAGE DEFINED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable percentage'

means 50 percent reduced (but not below 20 percent) by 1 percentage point for each full $1,000 amount by which the taxpayer's adjusted gross income for the taxable year exceeds $15,000.

''(B) COST-OF-LIVING ADJUSTMENT.—

''(i) IN GENERAL.—In the case of a taxable year beginning in a calendar year after 1995, subparagraph (A) shall be applied by increasing the $15,000 amount contained therein by the cost-of-living adjustment (as defined in section 1(f)(3)) for such calendar year determined by substituting ''1994'' for ''1992'' in subparagraph (B) of section 1(f)(3).

''(ii) ROUNDING.—If any increase determined under clause (i) is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10 (or if such increase is a multiple of $15, such increase shall be increased to the next highest multiple of $10).

''(b) EMPLOYMENT-RELATED EXPENSES.—For purposes of this section:

''(1) DETERMINATION OF ELIGIBLE EXPENSES.—

''(A) IN GENERAL.—The term 'employment-related expenses' means amounts paid for the following expenses, but only if such expenses are incurred to enable the taxpayer to be gainfully employed for any period for which there are 1 or more qualifying individuals with respect to the taxpayer:

''(i) expenses for household services, and

''(ii) expenses for the care of a qualifying individual.

Such term shall not include any amount paid for services outside the taxpayer's household at a camp where the qualifying individual stays overnight and shall not include any respite care expense taken into account under subsection (a).

''(B) EXCEPTION.—Employment-related expenses described in subparagraph (A) which are incurred for services outside the taxpayer's household shall be taken into account only if incurred for the care of—

''(i) a qualifying individual described in subsection (d)(1), or

''(ii) a qualifying individual (not described in subsection (d)(1)) who regularly spends at least 8 hours each day in the taxpayer's household.

''(C) DEPENDENT CARE CENTERS.—Employment-related expenses described in subparagraph (A) which are incurred for services provided outside the taxpayer's household by a dependent care center (as defined in subparagraph (D)) shall be taken into account only if—

''(i) such center complies with all applicable laws and regulations of a State or unit of local government, and

''(ii) the requirements of subparagraph (B) are met.

''(D) DEPENDENT CARE CENTER DEFINED.—For purposes of this paragraph, the term 'dependent care center' means any facility which—

''(i) provides care for more than 6 individuals (other than individuals who reside at the facility), and

''(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

''(2) DOLLAR LIMIT ON AMOUNT CREDITABLE.—

''(A) IN GENERAL.—The amount of the employment-related expenses incurred during any taxable year which may be taken into account under subsection (a) shall not exceed—

''(i) $2,400 if there is 1 qualifying individual with respect to the taxpayer for such taxable year, or

''(ii) $4,800 if there are 2 or more qualifying individuals with respect to the taxpayer for such taxable year.

The amount determined under clause (i) or (ii) (whichever is applicable) shall be reduced by the aggregate amount excludable from gross income under section 129 for the taxable year.

''(B) REDUCTION IN LIMIT FOR AMOUNT OF RESPITE CARE EXPENSES.—The limitation of subparagraph (A) shall be reduced by the amount of the respite care expenses taken into

account by the taxpayer under subsection (a) for the taxable year.

''(3) EARNED INCOME LIMITATION.—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amount of the employment-related expenses incurred during any taxable year which may be taken into account under subsection (a) shall not exceed—

''(i) in the case of an individual who is not married at the close of such year, such individual's earned income for such year, or

''(ii) in the case of an individual who is married at the close of such year, the lesser of such individual's earned income or the earned income of his spouse for such year.

''(B) SPECIAL RULE FOR SPOUSE WHO IS A STUDENT OR INCAPABLE OF CARING FOR HIMSELF.—In the case of a spouse who is a student or a qualified individual described in subsection (d)(3), for purposes of subparagraph (A), such spouse shall be deemed for each month during which such spouse is a full-time student at an educational institution, or is such

a qualifying individual, to be gainfully employed and to have earned income of not less than—

''(i) $200 if paragraph (2)(A)(i) applies for the taxable year, or

''(ii) $400 if paragraph (2)(A)(ii) applies for the taxable year.

In the case of any husband and wife, this subparagraph shall apply with respect to only one spouse for any one month.

''(c) RESPITE CARE EXPENSES.—For purposes of this section:

''(1) IN GENERAL.—The term 'respite care expenses' means expenses paid (whether or not to enable the taxpayer to be gainfully employed) for—

''(A) the care of a qualifying individual—

''(i) who has attained the age of 13, or

''(ii) who is under the age of 13 but has a physical or mental impairment which results in the individual being incapable of caring for himself,

during any period when such individual regularly spends at least 8 hours each day in the taxpayer's household, or

''(B) care (for not more than 14 days during the calendar year) of a qualifying individual described in subparagraph (A) during any period during which the individual does not regularly spend at least 8 hours each day in the taxpayer's household.

''(2) DOLLAR LIMIT.—The amount of the respite care expenses incurred during any taxable year which may be taken into account under subsection (a) shall not exceed—

''(A) $1,200 if such expenses are incurred with respect to only 1 qualifying individual for the taxable year, or

''(B) $2,400 if such expenses are incurred for 2 or more qualifying individuals for such taxable year.

''(d) QUALIFYING INDIVIDUAL.—For purposes of this section, the term 'qualifying individual' means—

''(1) a dependent of the taxpayer who is under the age of 13 and with respect to whom the taxpayer is entitled to a deduction under section 151(e),

''(2) a dependent of the taxpayer who is physically or mentally incapable of caring for himself, or

''(3) the spouse of the taxpayer, if he is physically or mentally incapable of caring for himself.

''(e) SPECIAL RULES.—For purposes of this section:

''(1) MAINTAINING HOUSEHOLD.—An individual shall be treated as maintaining a household for any period only if over half the cost of maintaining the household for such period is furnished by such individual (or, if such individual is married during such period, is furnished by such individual and his spouse).

''(2) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

''(3) MARITAL STATUS.—An individual legally separated from his spouse under a decree of divorce or of separate maintenance shall not be considered as married.

''(4) CERTAIN MARRIED INDIVIDUALS LIVING APART.—If—

''(A) an individual who is married and who files a separate return—

''(i) maintains as his home a household which constitutes for more than one-half of the taxable year the principal place of abode of a qualifying individual, and

''(ii) furnishes over half the cost of maintaining such household during the taxable year, and

''(B) during the last 6 months of such taxable year such individual's spouse is not a member of such household,

such individual shall not be considered as married.

''(5) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If—

''(A) paragraph (2) or (4) of section 152(e) applies to any child with respect to any calendar year, and

''(B) such child is under the age of 13 or is physically or mentally incapable of caring for himself,

in the case of any taxable year beginning in such calendar year, such child shall be treated as a qualifying individual with respect to the custodial parent (within the meaning of section 152(e)(1)), and shall not be treated as a qualifying individual with respect to the noncustodial parent.

''(6) PAYMENTS TO RELATED INDIVIDUALS.—No credit shall be allowed under subsection (a) for any amount paid by the taxpayer to an individual—

''(A) with respect to whom, for the taxable year, a deduction under section 151(e) (relating to deduction for personal exemptions for dependents) is allowable either to the taxpayer or his spouse, or

''(B) who is a child of the taxpayer (within the meaning of section 151(e)(3)) who has not attained the age of 19 at the close of the taxable year.

For purposes of this paragraph, the term 'taxable year' means the taxable year of the taxpayer in which the service is performed.

''(7) STUDENT.—The term 'student' means an individual who during each of 5 calendar months during the taxable year is a full-time student at an educational organization.

''(8) EDUCATIONAL ORGANIZATION.—The term 'educational organization' means an educational organization described in section 170(b)(1)(A)(ii).

''(9) IDENTIFYING INFORMATION REQUIRED WITH RESPECT TO SERVICE PROVIDER.—No credit shall be allowed under subsection (a) for any amount paid to any person unless—

''(A) the name, address, and taxpayer identification number of such person are included on the return claiming the credit, or

''(B) if such person is an organization described in section 501(c)(3) and exempt from tax under section 501(a), the name and address of such person are included on the return claiming the credit.

In the case of a failure to provide the information required under the preceding sentence, the preceding sentence shall not apply if it is shown that the taxpayer exercised due diligence in attempting to provide the information so required.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''

(b) CONFORMING AMENDMENTS.—

(1) Section 21 of such Code is hereby repealed.

(2) Paragraph (2) of section 129(b) of such Code is amended by striking out ''section 21(d)(2)'' and inserting in lieu thereof ''section 35(b)(3)(B)''.

(3) Subsection (e) of section 213 of such Code is amended by striking out ''section 21'' and inserting in lieu thereof ''section 35''.

(c) TECHNICAL AMENDMENTS.—

(1) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking out the item relating to section 35 and inserting in lieu thereof the following:

''Sec. 35. Dependent care services.
''Sec. 36. Overpayments of tax.''

(2) The table of sections for subpart A of such part IV is amended by striking out the item relating to section 21.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

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